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Identity-conscious services for diverse patients: A descriptive analysis of lesbian, gay, bisexual, and transgender-focused federally qualified community health centers

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ABSTRACT

Significant health disparities affect the lesbian, gay, bisexual, and transgender (LGBT) population. There has been growing attention to these disparities, with research focused on issues such as barriers to care, provider education, and disparate outcomes across the life course. However, there has been little research on the role of LGBT-focused health care settings. The objective of this study was to describe the patient populations and services among LGBT-focused federally qualified health centers (FQHCs). Eight LGBT FQHCs were identified. Health center histories, patient demographics, and services provided were identified through Health Resources and Services Administration health center program data and individual health center annual reports. Quantitative and qualitative descriptive analyses were conducted. Findings indicated that LGBT FQHCs were majority people-of-color-serving organizations. Compared to the national average of FQHCs, LGBT FQHCs served a higher proportion of people living with HIV and people experiencing homelessness. LGBT FQHCs also provided more mental health and enabling services than the national average. Findings suggested that LGBT FQHCs approached prevention and intervention services using a patient-centered, identity-conscious model of care. Health equity research should continue to focus on diverse health care contexts, including their respective community constituents, neighborhood settings, and identity-conscious services, programming, and resources.

KEYWORDS
health equity; health services; gender and sexual minorities; LGBT population; intersectionality; primary care

Across the United States, community health centers serve as primary care safety net delivery sites for uninsured and underinsured people (Heisler, 2016). Community health centers provide high-quality health and supportive services to all, regardless of insurance status or ability to pay. Achieving federally qualified health center (FQHC) status under the Health Center program, authorized under federal law in 1975, allows a community health

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center to receive federal funding, to accept Medicaid, Medicare, and other public insurances, and often, to expand its services. Becoming an FQHC is a highly competitive and resource-intensive process, and includes documenting that the patient population or area is medically underserved (Heisler, 2016; Hennessy, 2013). In 2015, there were 1,375 FQHCs, serving more than 24 million patients (Health Resources and Services Administration [HRSA], 2017a). FQHCs serve poverty-affected communities, and about half of FQHCs are in urban areas. Approximately one-third of FQHC patients nationwide fall below the federal poverty level and one in six FQHC patients is uninsured. By definition, community health centers are open to all health care seekers in their service area (HRSA, 2017c). However, many health centers reflect the uniqueness and specific histories of the communities in which they are located. Lesbian, gay, bisexual, and transgender (LGBT)-focused health centers follow in this tradition, and are committed to serving the needs of under-resourced LGBT communities.

Research has consistently documented significant health disparities in LGBT communities across many major indicators of health and mental health, including overall health status, access to health care, psychiatric disorders, depression, suicidality, substance use, and obesity (Institute of Medicine, 2011). These disparities are particularly salient within underserved LGBT communities, among low-income LGBT populations, and at the intersections of racial/ethnic health disparities (see Krehely, 2009; Wilson & Yoshikawa, 2007). Stigma is a leading explanation for health disparities within LGBT communities (Link & Phelan, 2006; Northridge, 2001). Specifically, health care access and utilization among LGBT people is impeded because the health care system itself, which is both heteronormative and cisnormative, is a primary source of the stigma LGBT people face in general. Bauer and colleagues (2009) argued that stigma within the health care system has resulted in the erasure of LGBT experiences at an institutional level (e.g., forms, policies) and at an informational level (e.g., research, education). Stigma against LGBT people is particularly complex considering intersecting stigmatized group memberships, keeping in mind that LGBT people are more likely to experience poverty and homelessness across the life course (Badgett, Durso, & Schneebaum, 2013).

Health equity research within LGBT communities, and specifically LGBT communities of color, is beginning to gain traction in a variety of disciplines, such as public health, medicine, social work, and psychology. For example, LGBT health research has increasingly focused on access issues (e.g., Dahlhamer, Galinksy, Joestl, & Ward, 2016; Wilson & Yoshikawa, 2007), provider education (e.g., Kelley, Chou, Dibble, & Robertson, 2008; Obedin-Maliver et al., 2011; Rutherford, McIntyre, Daley, & Ross, 2012), and disparate outcomes across the life course (e.g., Addis, Davies, Greene,

MacBride-Stewart, & Shepard, 2009; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Xavier, Honnold, & Bradford, 2007). However, little is known about the role of LGBT-focused health centers in serving health disparity populations. The current study put into focus the significance of LGBT-focused FQHCs and aimed to provide a descriptive overview of LGBT FQHCs by asking the following: (a) Who are LGBT FQHCs? (b) Who do LGBT FQHCs serve? (c) What services are provided? and (d) How do services attend to diversity within the community? The objective of this study was to describe the patient populations and various patient services among LGBT FQHCs, with specific focus on organizational attention given to intersecting social identities, such as gender, age, race/ethnicity, and sexual orientation. While this was primarily an inductive study, guiding hypotheses were that (a) the patient and service profiles of LGBT FQHCs would differ from the universe of FQHCs nationally, and (b) LGBT FQHCs would provide tailored care specific to the needs of sexual and gender minorities.

Methods

Sample

Through a review of the literature, community health center database searches (e.g., CenterLink, National Association of Community Health Centers), and an examination of Health Resources and Services Administration (HRSA) health center grantee data, eight LGBT FQHCs located across the United States were identified (see Table 1). An FQHC was classified as an "LGBT" FQHC if its mission statement expressed an explicit orientation to serving LGBT populations. Two FQHCs renowned for their historical commitment to LGBT communities, Legacy Community Health in Houston, Texas, and Chase Brexton Health in Baltimore, Maryland, were excluded based on this inclusion criterion, as they did not specifically identify serving the LGBT community as their core organizing purpose in their mission statements. To support this exclusion decision, the profiles of Legacy and Chase Brexton were compared to the sample, and meaningful differences were identified. Specifically, Legacy served more

Table 1. Overview of LGBT FQHCs in the United States.

Center	Location	Year Founded	Year FQHC Status Granted
API Wellness Center	San Francisco, CA	1987	2015
Apicha Community Health Center	New York City, NY	1989	2015
Callen-Lorde Community Health Center	New York City, NY	1983	2015
Fenway Health	Boston, MA	1971	2002
Howard Brown Health	Chicago, IL	1974	2014
Los Angeles LGBT Center	Los Angeles, CA	1969	2013
Lyon-Martin Health Services	San Francisco, CA	1980	2015
Whitman-Walker Health	Washington, DC	1978	2013

than 6 times the number of patients and almost half of Legacy patients were children. Chase Brexton served more patients than the highest-serving center in the sample, and more children than the average center in the sample, as well. One major LGBT-serving community health center, the Mazzoni Center in Philadelphia, Pennsylvania, was excluded because while they receive federal funding and are on the path to FQHC status, at the time of the study, they had not yet achieved status. Of the eight identified LGBT FQHCs, four received FQHC status in 2015, demonstrating the relatively recent presence of LGBT FQHCs within the general landscape of FQHCs. All LGBT FQHCs were located in major urban areas, including Boston, New York City, Chicago, Washington, DC, San Francisco, and Los Angeles.

Data

This study drew upon existing data from multiple sources. Health Center Program grantee data from 2015 (the most recent year available) at the national and individual health center level were used to determine patient demographics and rates of service provision. These data were made available through the Uniform Data System managed by HRSA (see https://bphc.hrsa.gov/uds/datacenter.aspx). Every year, FQHCs and other grantees through the Bureau of Primary Health Care are required to report back to HRSA on a number of patient and service panel questions using a uniform reporting system (see HRSA, 2017b). These systematically collected data allowed for comparisons between specific centers and groups of centers to the national average. To supplement HRSA data, additional information was collected from health center archival and administrative data as reported on center websites and in annual reports. Annual reports from each center across the past five years (2010–2015) were collected and reviewed, as available, to account for any significant changes in patient profiles or services in recent years. Data from annual reports were standardized as much as possible and entered into an Excel worksheet for management and analysis. Data from annual reports allowed for more comprehensive analyses, since there were missing data in the HRSA uniform data system. For example, gender data were collected through annual reports since the HRSA uniform data system only allows for two genders to be reported.

Analytic procedure

Results from this study were based on descriptive quantitative and qualitative analyses. Descriptive statistics were used to describe patient

demographic information and service provision. The quantitative analyses were facilitated by the use of Excel and SPSS software. A qualitative content analysis was also conducted to examine textual data from center websites and annual reports, including the historical timeline and mission statement of each center, as well as descriptions of various respective health, human, and social services resources, and programming (Forman & Damschroder, 2007). This method of qualitative analysis relies upon minimal interpretation by the researcher, and is a fundamental analytic technique is descriptive qualitative research (Sandelowski, 2000). Corresponding analytic techniques including coding and categorizing qualitative data and charting both qualitative and quantitative data were employed. Rigor was enhanced through an iterative analytic process, documented through an audit trail (Miles, Huberman, & Saldana, 2014). This included data triangulation, specifically cross-checking results from one data source with that from another, and reviewing emerging findings in the context of reports and guidelines concerning the FQHC program regulations.

Lyon-Martin Health Services was excluded from all analyses because they operate in partnership with a larger FQHC with a number of sites, and data specific to Lyon-Martin information could not be disaggregated. Efforts were made to acquire data from Lyon-Martin, but were unsuccessful.

Findings

A synthesis of LGBT FQHC organizational histories indicated that LGBT community health centers began to emerge in the late 1960s and early 1970s (see Fenway Health, 2015; Howard Brown Health, 2016; Los Angeles LGBT Center, 2015). Over time, LGBT community health centers have expanded, shrunk, and otherwise evolved alongside changing health care policies, funding opportunities, and the devastating effects of the HIV/AIDS epidemic. The path to federally qualified status for LGBT health centers has been stymied by the fact that the LGBT population has not been designated as a medically underserved population by the federal government, although the National Institutes of Health (NIH) now acknowledge the LGBT population as a health disparity population (National Institutes of Health, 2016). Despite numerous challenges, to date, at least 10 historically LGBT-serving health centers have achieved FQHC status (Fenway Institute, 2014). This may be in part due to their geographic location, the intersection between the LGBT community and poverty, and the corresponding lack of access to culturally competent providers (Fenway Institute, 2014).

On their organizational trajectories to qualification, some LGBT community health centers have chosen to shift or step away from their explicit mission to serve LGBT communities (e.g., Chase Brexton Health, Legacy Community Health). These organizational decisions may be attributed to a number of factors, including being absorbed by or absorbing a center with a distinct, non-LGBT-specific mission. These centers have been able to maintain LGBT-specific services, but have elected to not be explicit in their LGBT focus perhaps in part to cast a wider net in the community, given the stigma associated with being a gender or sexual minority. Described here are the eight LGBT FQHCs who have maintained their explicit commitment to LGBT populations in their mission statements.

API Wellness (San Francisco, CA)

Started in 1987 and formally founded in 1996, API Wellness was one of the first Asian and Pacific Islander-focused HIV/AIDS organizations in North America (API Wellness Center, 2015). Its community and social justice-oriented mission statement reads:

> API Wellness is an LGBTQ and people of color health organization that transforms lives by advancing health, wellness, and equality. We believe everyone deserves to be healthy and needs access to the highest-quality health care. We foster resilience, strength, connection, health, and wellness for all communities. To us, health care will always be grounded in social justice. (API wellness mission source: https://apiwellness.org/about/)

API Wellness achieved FQHC status in 2015. That year, API Wellness served approximately 600 patients, 464 of whom were living with HIV. Seventy-four percent of patients were people of color, 34% identified as transgender or gender nonconforming, and 36% identified as lesbian, gay, bisexual, or queer. Health services included (but were not limited to) primary care, family planning, HIV/STD testing, transgender health, mental health, and substance use. Other resources and programming included health education, a trans drop-in center, support groups, needle exchange, counseling, and case management.

Apicha Community Health Center (New York City, NY)

What is today known as Apicha Community Health Center began in 1989 as the Asian and Pacific Islander Coalition on HIV/AIDS (Apicha Community Health Center, 2017). In 2009 Apicha Community Health Center shifted to a primary care model, and in 2015 achieved FQHC status.

> Our mission at Apicha Community Health Center is to improve the health of our community and to increase access to comprehensive primary care, preventive health services, mental health, and supportive services. We are committed to excellence and to providing culturally competent services that enhance the quality of life. We advocate for and provide a welcoming environment for underserved and vulnerable people, especially Asians and Pacific Islanders, the LGBT Community and individuals living with and affected by HIV/AIDS. (APICHA mission statement source: https://www.apicha.org/health-center-in-new-york-city/)

In 2015, Apicha served 4,400 patients. According to their 2015 annual report, 73% of patients were people of color and 64% identified as LGBT. Approximately one-third of Apicha patients were living with HIV in 2015. Health services included (but were not limited to) primary medical care, HIV primary care, transgender primary care, sexual health services, and behavioral health services. Other resources and programming included a program for Asian and Pacific Islanders (A&PI) who identify as lesbian, gay, bisexual, transgender, queer, questioning, and intersex (LGBTQI), training for providers, and nutrition and health education.

Callen-Lorde Community Health Center (New York City, NY)

The first community-based HIV/AIDS clinic in the United States, the history of Callen-Lorde Community Health Center dates back to 1983 (Callen-Lorde Community Health Center, 2015). Its mission statement reads:

> Callen-Lorde Community Health Center provides sensitive, quality health care and related services targeted to New York's lesbian, gay, bisexual, and transgender communities—in all their diversity—regardless of ability to pay. To further this mission, Callen-Lorde promotes health education and wellness, and advocates for LGBT health issues. (Callen-Lorde mission statement source: http://callen-lorde.org/about/)

Callen-Lorde achieved FQHC status in 2015. That year, Callen-Lorde served more than 15,000 patients, approximately 4,000 of whom were living with HIV. Fifty-four percent of patients were people of color, and 21% of patients identified as transgender or gender nonconforming. Health services included (but were not limited to) primary medical, mental health, HIV primary medical care, lesbian and bisexual women's health, transgender services, oral health, care coordination, sexual health, and pharmacy. Other resources and programming included health outreach to LGBTQ adolescents and young adults, with specific attention to homeless youths.

Fenway Health (Boston, MA)

Fenway Health was founded in 1971 (Fenway Health, 2015). While it did not begin as an HIV clinic, Fenway Health has made significant

contributions to the prevention and treatment of, and research on, HIV/AIDS, especially in North America.

> The mission of Fenway Health is to enhance the wellbeing of the lesbian, gay, bisexual and transgender community and all people in our neighborhoods and beyond through access to the highest quality health care, education, research and advocacy. (Fenway mission statement source: http://fenwayhealth.org/about/history/)

Fenway achieved FQHC status in 2002, making it the first LGBT FQHC. In 2015, Fenway Health served more than 24,000 patients, approximately 2,000 of whom were living with HIV. Just over 30% of patients were people of color, and an estimated 1,200 patients identified as transgender or gender nonconforming. Health services included (but were not limited to) primary medical, behavioral health, dental care, vision, transgender health, women's health, and complementary therapies. Other resources and programming included LGBT parenting, safe-sex resources, and an LGBT aging research project with related programming and services.

Howard Brown Health (Chicago, IL)

Howard Brown Health was founded in 1974 by an active group of gay-identified medical students (Howard Brown Health, 2016). The early days of Howard Brown Health were focused on the treatment of Hepatitis B, and later the center took on a leadership role in addressing the HIV/AIDS epidemic. The mission of Howard Brown Health states:

> Howard Brown Health exists to eliminate the disparities in healthcare experienced by lesbian, gay, bisexual and transgender people through research, education and the provision of services that promote health and wellness. (Howard Brown mission source: https://howardbrown.org/mission-and-overview/)

Howard Brown achieved FQHC status in 2014. In 2015, Howard Brown served nearly 20,000 patients. Approximately 34% of patients were people of color and an estimated 10% of patients identified as transgender or gender nonconforming. Nearly half (48%) of patients identified as gay, 5% as lesbian, 9% as bisexual, and 6% as queer. Health services included (but were not limited to) men's, women's, and transgender health; geriatric services, pediatric services, behavioral health, alternative insemination; and youth center health clinic, HIV services, resource advocacy, and drop-in services. Other resources and programming included health education, violence recovery, smoking cessation support, transgender and intersex support, harm reduction, resources for homeless LGBTQ youth, including a social space, clothing vouchers, laundry, food bank, peer advocate project, meetings and youth-led

workshops, education and employment services, a GED program, and insurance enrollment.

Los Angeles LGBT Center (Los Angeles, CA)

Founded in 1969, the Los Angeles LGBT Center was one of the first LGBT community health centers in the United States (Los Angeles LGBT Center, 2015). Throughout the years, the Los Angeles LGBT Center has been committed to the multifaceted issues facing the community, including the HIV/AIDS crisis. Its mission statement reads:

> The Los Angeles LGBT Center is building a world where LGBT people thrive as healthy, equal, and complete members of society. (Los Angeles LGBT center mission source: https://lalgbtcenter.org/about-the-center/mission)

The Los Angeles LGBT Center achieved FQHC status in 2013. In 2015, the Center was home to 11,763 patients, approximately 2,900 of whom were living with HIV. More than 57% of patients were people of color. Health services included (but were not limited to) primary medical, transgender care, HIV care, testing, and prevention, mental health, addiction recovery services, and pharmacy. Other resources and programming included a community center with legal, housing, youth, family, employment, senior, and violence recovery services, social networking, coming-out workshops, and LGBT seniors groups.

Lyon-Martin Health Services (San Francisco, CA)

What is known today as Lyon-Martin Health Services was originally started by a cadre of lesbian-identified doctors, nurses, and volunteers who were committed to addressing the specific health concerns of lesbian women (Lyon-Martin Health Services, 2017). Today, the mission of Lyon-Martin reads:

> Lyon-Martin Health Services provides excellent health care to heterosexual women, bisexual women, lesbians and transgender people in a safe and compassionate environment, with sensitivity to sexual orientation and gender identity; all services are regardless of ability to pay. (Lyon-Martin mission source: http://lyon-martin.org/about-us)

Officially founded in 1980, Lyon-Martin became an FQHC in 2015 when it merged with HealthRIGHT 360. Because of this merger, the specific patient profiles and services provided were not made available at the time of this study. Health services included (but were not limited to) primary care, HIV primary care, transgender health care, gynecologic care, breast/chest health services, integrated behavioral health, and mental health services, including group therapy.

Whitman-Walker Health (Washington, DC)

First known in 1973 as the Gay Men's VD Clinic, Whitman-Walker Health was formally founded in 1978, just a few years prior to the AIDS epidemic (Whitman-Walker Health, 2015).

> Our mission is to be the highest quality, culturally competent community health center serving greater Washington's diverse urban community, including individuals who face barriers to accessing care, and with a special expertise in Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) and HIV care. (Whitman-Walker mission source: https://whitman-walker.thankyou4caring.org/page.aspx?pid=391)

Whitman-Walker achieved FQHC status in 2013. In 2015, Whitman-Walker served nearly 15,000 total patients, approximately 40% of whom were living with HIV. Two-thirds of patients were people of color, and approximately 6% of patients identified as transgender or gender nonconforming. Nearly half (48%) of patients identified as gay, lesbian, or bisexual. Health services included (but were not limited to) transgender care, gay men's health STD clinic, HIV medical care, dental care, pharmacy, HIV and STD testing, aesthetic medicine, nutrition, acupuncture, and behavioral health and community health services. Other resources and programming included legal services, health education for lesbian, bisexual women, and trans people, a healthy relationships program, a program for current former drug users living with HIV, a peer mentor program, a program specifically for African-Americans living with HIV, and creative art therapy.

LGBT FQHC patient population and services

Overall, in 2015, LGBT FQHCs served more than 71,000 patients (see Table 2). However, on average, non-medical clients (e.g., those seeking legal, employment, or other supportive services) comprised approximately 25% of total people served by LGBT FQHCs, making the estimated total number of people served by LGBT FQHCs (patients and non-medical clients) nearly 95,000. LGBT FQHCs are majority people-of-color-serving health centers, with on average 56% of patients identifying as racial and/or ethnic minorities. The vast majority (96%) of LGBT FQHCs' patient population was adults ages 18 to 64 compared to a national average of 61%. Approximately 1 in 7 patients served by LGBT FQHCs identified as transgender or gender nonconforming. Among those centers reporting sexual orientation data ($N = 3$), 50% of patients identified as lesbian, gay, bisexual, or queer. The vast majority of patients (96%) were adults ages 18 to 64. Almost 1 in 4 (22.7%) LGBT FQHC patients were living with HIV in 2015, compared to a national FQHC rate of 1 in 125 (0.8%). LGBT FQHC patient populations were comprised of higher percentages of homeless patients (19.8%) and uninsured patients (32.8%) compared to the national

Table 2. LGBT FQHC patient characteristics and services.

Variable	*N*	Mean	Min	Max	*SD*	Nat'l Avg (*N* = 1,375)
Patient characteristics (%)						
Adult (18–64)	5	96.0	94.3	98.4	1.7	60.9
Racial and/or Ethnic Minority	7	56.6	29.8	84.3	19.5	62.4
Transgender/Gender nonconforming	5	15.4	6.0	34.0	12.1	–
Lesbian, gay, bisexual, or queer	3	50.7	36.0	68.0	16.2	–
Best-served in another language	5	8.5	2.0	13.8	4.6	22.8
At or below 200% of poverty line	5	56.9	0.0	84.8	33.8	92.2
Uninsured	6	32.8	11.4	65.0	23.7	24.4
Homeless	5	19.8	1.9	70.0	28.7	4.9
HIV+	5	22.7	4.1	40.3	15.4	0.8
Services (% of patients)						
Medical	5	88.0	76.4	100.0	10.0	84.9
Dental	4	10.5	0.0	21.6	12.1	21.4
Mental health	5	22.3	3.3	39.0	12.0	6.1
Substance abuse	4	0.7	0.0	1.7	0.9	0.1
Vision	4	3.9	0.0	15.7	7.9	2.1
Enabling	5	16.8	0.0	53.7	24.9	9.8
Total patients	7	13193	600	24400	8357	17770
Total cost per patient	5	3446.56	1622.11	4552.26	1376.87	826.84

Notes. Sample size varies due to missing data. Total patients, sexual orientation, and gender data were from health center annual reports. All other data were from Health References and Services Administration uniform reporting system.

average of FQHCs (4.9% and 24.4%, respectively). LGBT FQHCs served fewer patients at or below 200% of poverty (56.9%) and fewer patients best served in another language (8.5%) than the national average (92% and 22.8%, respectively).

LGBT FQHCs provided comprehensive health services. All LGBT FQHCs provided primary medical care, transgender care, and HIV/STI testing. There were, however, differences in rates of specific service provision. In 2015, a higher percentage of LGBT FQHC patients received mental health services (22.3%) compared to the national FQHC average of 6.1%. LGBT FQHC patients also received higher rates of enabling services (16.8%), nonclinical services that aim to increase access to health care and improve health outcomes, including health education, interpretation, and case management, compared to the national FQHC average of 9.8%. A lower percentage of LGBT FQHCs' patients received dental services (10.5%) compared to the national FQHC average (21.4%). Finally, LGBT FQHCs provided services at a higher cost per patient ($3446.56), more than 4 times higher than the national FQHC average of $826.84. All LGBT FQHCs received funding from the Ryan-White HIV/AIDS Program and were AIDS Services Organizations (ASOs). Furthermore, all LGBT FQHCs were recognized as Patient-Centered Medical Homes, a model of care that emphasizes the involvement of patients, team-based, coordinated care, and enhanced access to care (Peikes, Genevro, Scholle, & Torda, 2011).

All LGBT FQHCs offered identity-conscious services, resources, and programming (clinical and nonclinical) targeted to specific racial, sexual

Table 3. Examples of identity-conscious services at LGBT FQHCs.

Service	Race	Sexuality	Gender	Age
Program for African-Americans living with HIV	X			
HIV prevention services for people of color	X			
Young-men-of-color group	X			X
GLBTQI A&PI youth mentorship for empowerment	X	X	X	X
LGBT seniors, elders, and aging groups		X	X	X
Health outreach to LGBTQ teens, specifically homeless youth		X	X	X
Support group for women in post-heterosexual relationships		X	X	
Bisexual women's support group		X	X	
Health education workshops for lesbian, bisexual women, and trans people		X	X	
HIV prevention services for trans and gender-nonconforming youth			X	X
Trans youth drop-in center			X	X
HIV + women support group			X	
Trans women support group			X	
Transgender and intersex support group			X	
Peer support and leadership development for youth				X

orientation, and gender identity groups, youths, and elders (see Table 3). This included support groups and individual counseling concerning issues related to gender and sexuality, with particular attention to the intersections of age, race, and socioeconomic status and illness experiences. This included, for example, trans-women-of-color support groups, a young-men-of-color group, and support group for African-Americans living with AIDS. Resources, services, and programming such as health education, legal services, housing and employment assistance, GED preparation, violence recovery, and insurance enrollment were characteristic of LGBT FQHCs.

Discussion

Findings from this study begin to establish a foundational understanding of LGBT-focused FQHCs in the United States. Eight FQHCs were identified as having an LGBT focus. At the descriptive level, there were important differences in patient populations and services among LGBT FQHCs compared to the national population of FQHCs. While there were significant data missing as far as the sexual orientation and gender identities of patients of LGBT FQHCs, study findings did indicate that LGBT-focused FQHCs provided more services in some of the major health disparity areas among the LGBT population. Consistent with the health disparities literature, we see more LGBT FQHC patients experiencing homelessness, receiving enabling services and mental health services, and seeking HIV care, including HIV education, testing, prevention, and HIV primary care (National LGBT Health Education Center, 2016). LGBT FQHCs' patient demographics differed from the national average across several key categories: age, socioeconomic status, and primary language. Specifically, LGBT FQHCs served fewer elders, youths, people experiencing poverty, and patients who require services in languages other than English compared to the national average. These differences might be attributable to differences

in the general population, increased care options given the urban setting of LGBT FQHCs, and the financial strain of offering services in multiple languages.

Building on key characteristics of person-centered care (respect of values, preferences, and inclusion of family and social networks), the identity-conscious health service delivery model reflected in LGBT FQHCs centered patients' social identities, as well as intersecting likelihoods of experiences of stigma and marginalization. Among LGBT FQHCs, this approach seemed to result in identity-appropriate, comprehensive strategies for prevention and intervention efforts, including health promotion, education, and other community-based programming. For example, all LGBT FQHCs had services, programming, or other resources that tapped into the diversity of the LGBT community, acknowledging the intersecting experiences of race, socioeconomic status, and age. LGBT FQHCs also provided legal, housing, education, and employment resources. These findings signaled that through this integrated, inclusive approach, LGBT FQHCs may enhance the life trajectories of their patients, well beyond the scope of health outcomes alone. This multidimensional lens may inform strategies to expand organizational and institutional conceptualizations of what LGBT-serving health centers are, who they serve, what research is needed to document impact of LGBT FQHCs, and how policy and practice can shape LGBT health equity.

Limitations

One of the most significant limitations to health center research concerning gender and sexuality, including the current study, is the completeness and accuracy of data. HRSA data do not include comprehensive gender and sexual orientation data, and community health centers have different approaches for collecting and reporting demographic information. For example, within several health center reports, gender identity reporting was limited to the number of transgender patients, rather than reporting the full range of gender identities. In addition, it should be noted that not all patients served by LGBT FQHCs are LGBT-identified themselves; centers who reported sexual orientation data averaged around 50% of patients identifying as lesbian, gay, bisexual, or queer. It is unclear if and how sexual orientation information is collected across all FQHCs; however, research has demonstrated high rates of acceptability of sexual orientation and gender identity questions among health center patients (Cahill, 2014). Furthermore, these data-related issues precluded analyses related to intersecting social identities; the available data did not allow for an in-depth examination of specific intersections of social identities and service use.

While the entire network of LGBT-affirming community health centers is highly valuable, only LGBT community health centers who had achieved FQHC status and FQHCs who identified an LGBT focus in their mission statements were included in this study. Important insights could be gathered from examining non-FQHC LGBT-focused health centers. Furthermore, when interpreting findings, it is important to consider that the sample size varied significantly across analyses and to note that within several variables (e.g., 200% of poverty line, enabling services) there is substantial variance across centers. Given that the sample size was considerably small already, caution should be exercised when interpreting results.

Implications

This study highlighted the role of health centers in communities, particularly concerning those affected by multiple forms of oppression and marginalization. Results could be used to inform policy recommendations that decentralize heterosexuality and cisnormativity (the normalizing of non-transgender identity), and call attention to various communities' exclusion from the social right to quality health services (Epstein, 2003). Advocates have argued for the designation of the LGBT population as a medically underserved population (MUP) and a Health Professional Shortage Area (HPSA) population group based on the high rates of poverty and limited access to access to quality care, which have resulted in significant disparities in health (Fenway Institute, 2014). However, without accurate and complete population data, and because the MUP/HPSA designation itself is imprecise, it has been a challenge to argue the case for LGBT inclusion (Hennessy, 2013). Findings from this study support the call for an expansion of systematic data collection concerning the LGBT population at both the national and local levels (Institute of Medicine, 2011).

LGBT FQHCs' patient demographics differ from the national average across several key categories. This may indicate that additional resources are needed to reach and increase access for LGBT elders, youths, and people experiencing poverty, and to provide services in languages other than English. At the same time, additional research is needed to better understand why some of these groups, and people with certain care needs, may choose not to visit an LGBT FQHC. What are the specific barriers to care within these communities? What is the LGBT FQHC patient experience like, particularly across various demographic groups? Previous research has shown that barriers of care for LGBT people exist across the access continuum, from perceiving the need for care to service actualization, and that access issues are associated with delayed and foregone care (Romanelli &

Hudson, 2017). Among LGBT FQHC patient populations it is unclear if there are underlying issues of delayed or foregone care, if perhaps these populations are healthier overall, or if they seek care elsewhere within formal and informal health care settings and systems.

Based on the data used in this study, the mechanism driving the higher average cost per patient among LGBT FQHCs was indeterminable. However, findings may suggest at least two possible explanations: (a) the higher rate of HIV/AIDS services (especially given all LGBT FQHCs were ASOs) and (b): it may be more costly to comprehensively address health disparities in multiple marginalized communities, given the significant barriers to care experienced by sexual, gender, and racial/ethnic minorities and people experiencing poverty. Future research should continue to explore models for providing cost-effective comprehensive medical services, resources, and programming in order to facilitate the success and growth of LGBT FQHCs.

Concurrently, future research should explore how identity-conscious health services might lead to better provider-patient interactions, adherence and engagement in treatment, and health outcomes. LGBT FQHCs centered their patients' intersecting social identities and experiences of oppression. Undoubtedly, LGBT FQHCs serve important roles in their communities and among their constituents. Health equity research should include special attention to diverse health care settings, including services, programming, and other resources. In these unclear and changing times, particularly within changing political contexts, LGBT community health centers need support to achieve grantee status, without losing their tailored approach and community-centeredness.

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